IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. **Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic*, to the effect that the student has been examined and may safely engage in athletic competition.**

This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address _____ Phone # _____

Parent's/Guardian's Name _____ Date _____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)

	Yes	*No*	*Has this student ever had?*
1.	_____	_____	Chronic or recurrent illness or injury?
2.	_____	_____	Any illness lasting more than one (1) week?
3.	_____	_____	Mononucleosis or Rheumatic fever?
4.	_____	_____	Hospitalizations (Overnight or longer)?
5.	_____	_____	Surgery, other than tonsillectomy?
7.	_____	_____	Allergies to pollen, stinging insects, food, etc.?
8.	_____	_____	High blood pressure or high cholesterol?
9.	_____	_____	Heart problems (Racing, murmur, skipped beats, infection, etc.?)
10.	_____	_____	Chest pressure or pain with exercise?
11.	_____	_____	Dizziness or fainting with exercise?
12.	_____	_____	Excessive shortness of breath with exercise?
13.	_____	_____	Seizures or frequent headaches?
14.	_____	_____	Head injury, concussion, unconsciousness?
15.	_____	_____	Numbness, tingling or weakness in arms or legs with contact?
16.	_____	_____	Headache, memory loss, or confusion with contact?
17.	_____	_____	Severe muscle cramps or become ill when exercising in the heat?

	Yes	*No*	*Has this student ever had?*
18.	_____	_____	Asthma?
19.	_____	_____	Epilepsy, or other seizures?
20.	_____	_____	Diabetes?
21.	_____	_____	Herpes infection?
22	_____	_____	Marfan Syndrome?
23.	_____	_____	Eyeglasses or contact lenses?

	Yes	*No*	*Is there a history of?*
24.	_____	_____	Injuries requiring medical treatment?
25.	_____	_____	Neck injury?
26.	_____	_____	Knee injury or surgery?
27.	_____	_____	Other serious joint injuries?
28.	_____	_____	Use of protective equipment or braces?

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29.	**_____**	**_____**	**Has a doctor ever denied or restricted your participation in sports for any reason?**
30.	**_____**	**_____**	**Do you have any concerns that you would like to discuss with your doctor?**

	Yes	*No*	*Family History:*
31.	_____	_____	Does anyone in your family have Marfan syndrome?
32.	_____	_____	Has anyone in your family died suddenly for no apparent reason?
33.	_____	_____	Has anyone in your family had a heart attack at less than 55 years of age?

*Use this space to explain any **"YES"** answers from above (questions #1-33) or **to provide any additional information**:*

_____

_____

_____

34. _____ _____ Are you allergic to any prescription or over-the-counter medications? *If yes, list:*_____

35. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:

A. _____ B. _____ C. _____

36. Year of last known: Tetanus (lockjaw) vaccination: _____ Meningitis vaccination: _____

37. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least*** _____

38. Are you happy with your current weight? ***Yes*** _____ ***No*** _____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? _____

2. <u>In the past 12 months</u>, what is the longest time you have gone between menstrual periods? _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14(1). ***This evaluation is only to determine readiness for sports participation. It should NOT be used as a substitute for regular health maintenance examinations.***

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____/_____ *(Repeat, if abnormal _____/_____)* Vision R 20/_____ L 20/_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Pupil Size (Equal/Unequal)			
4. Mouth & Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. *(See questions 26-30)*			
14. Neurological			

Comments regarding abnormal findings: _____

_____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

_____ **FULL & UNLIMITED PARTICIPATION**

_____ **LIMITED PARTICIPATION** - *May **NOT** participate in the following (checked):*

_____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

_____ **CLEARANCE PENDING DOCUMENTED FOLLOW UP OF** _____

_____ **NOT CLEARED FOR ATHLETIC PARTICIPATION DUE TO** _____

_____ _____

Licensed Medical Professional's Name *(Printed)* **Date**

_____ _____

Licensed Medical Professional's Signature **Phone**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I also **give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury.

_____ _____

Name of Parent or Guardian *(Printed)* Signature of Parent of Guardian

_____ _____

Address (Street/PO Box, City, State, Zip) Phone Number

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can certainly be attached to it. *5/09*